Women/Maternal Health

State Action Plan Table (Michigan) - Women/Maternal Health - Entry 1

Priority Need

Reduce barriers, improve access, and increase the availability of health services for all populations

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

A) Increase the percent of females aged 15 to 44 who use a most or moderately effective contraceptive method from 81% to 84% by 2020

B) Increase the percent of women who report ever having discussed reproductive life planning during a visit with a doctor, nurse, or other health professional from 64% to 65% by 2020

C) Increase the percent of women with a past year preventive medical visit from 68% to 75% by 2020

Strategies

A1) Support the provision of contraception to low-income, uninsured, and underinsured women in the Family Planning Program A2) Host at least one clinical practicum on the insertion and removal of long-acting reversible contraceptives (LARC) for Title X and other health care providers A3) Support urban and rural hospitals' provision of immediate post-partum LARC via the Michigan Collaborative for Contraceptive Access A4) Promote contraceptive and reproductive health services offered by the Family Planning Program in communities with high infant mortality with significant African American and Hispanic populations A5) Utilize the Family Planning Program's competitive local request for proposal (RFP) to improve access to reproductive health services within communities with high minority populations and infant mortality rates

B1) Discuss reproductive life planning (RLP) with at least 60,000 women in the Family Planning Program B2) Assist Medicaid with pay-for-performance (P4P) client-centered contraceptive counseling for Health Plans B3) Expand use of client-centered RLP and contraceptive counseling among programs that serve at-risk women B4) Disseminate preconception health messages on MDHHS social media accounts B5) Offer at least one reproductive justice-focused pregnancy intention training to Family Planning and other healthcare providers

C1) Assess racial/ethnic health care access disparities in Michigan C2) Promote referrals to primary care providers within Family Planning clinics C3) Partner with Medicaid and Medicaid Health Plans to educate Family Planning providers on policy issues C4) Disseminate well-woman and preventive health messages on MDHHS social media accounts

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (Michigan) - Women/Maternal Health - Entry 2

Priority Need

Increase access to and utilization of evidence-based oral health practices and services

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

A) Increase the number of medical and dental providers trained to treat, screen and refer pregnant women and infants to oral health care services

B) Increase the number of pregnant women receiving oral health care services

Strategies

A1) Offer and evaluate training for medical and dental professionals A2) Disseminate Perinatal Oral Health Guidelines and promotional and educational materials A3) Develop and implement a communication plan that promotes Medicaid policy changes A4) Develop and promote materials around oral health and health equity for providers

B1) Analyze PRAMS data to assess racial and ethnic healthcare access B2) Begin to develop a plan from the PRAMS racial and ethnic healthcare access to address oral health and health equity issues B3) Collaborate with partners to facilitate alternative models of prenatal oral health care B4) Provide education to women via the Perinatal Oral Health WIC Module

ESMs	Status
ESM 13.1.1 - Number of medical and dental professionals who receive perinatal oral health education through MDHHS	Active
ESM 13.1.2 - Percent of pregnant women who receive at least one oral health service through Medicaid during the perinatal period	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Perinatal/Infant Health

State Action Plan Table (Michigan) - Perinatal/Infant Health - Entry 1
Priority Need
Support coordination and linkage across the perinatal to pediatric continuum of care
NPM
NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Objectives
A) By 2020, support the implementation and evaluation of Regional Perinatal Quality Collaboratives (RPQCs) in all ten regions
B) By 2020, increase Risk Appropriate Care for infants from baseline data indicators by 20%: Very Low Birth Weight (VLBW); Low Birth Weight (LBW); and prematurity
C) By 2020, expand quality improvement efforts related to the prevention and response of Perinatal Substance Use via the Regional Perinatal Quality Collaboratives (RPQCs)
Strategies
A1) Provide financial and staff support to assist Regional Perinatal Quality Improvement Initiatives A2) Assess for, and pursue, expansion of RPQC quality improvement efforts in other regions in Michigan A3) Promote department directives (especially to address health disparities and inequities in low/very low birth weight and prematurity) to ensure alignment with statewide maternal infant health strategies, including the Mother Infant Health and Equity Improvement Plan (MIHEIP)
B1) Promote case management/care coordination for at-risk pregnant women in Michigan through evidence-based programs such as CenteringPregnancy©; CenteringParenting©; maternal, infant and early childhood home visiting (MIECHV); and maternal infant health program (MIHP) B2) Participate in The American College of Obstetricians and Gynecologists (ACOG) Alliance for Innovation on Maternal Health (AIM) B3) Lead statewide maternal and infant vitality efforts through the statewide Mother Infant Health and Equity Improvement Plan (MIHEIP)
C1) Promote opioid use disorder prevention and increase screening and identification of women (especially those of childbearing age) for opioid use disorder through Regional Perinatal Quality Collaboratives. Data stratification will allow the RPQCs to identify disparities and inequities in PSUD populations C2) Enhance capacity to provide treatment for women identified as affected by opioid use disorder through cross-sector partnerships within each regional perinatal quality collaborative C3) Improve workforce development and training programs to improve education and training related to Neonatal Abstinence Syndrome (NAS) and maternal care perinatally and postpartum via regional perinatal quality collaboratives
NOMs
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table (Michigan) - Perinatal/Infant Health - Entry 2	
Priority Need	
Support coordination and linkage across the perinatal to pediatric continuum of care	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
A) Increase percentage of Baby-Friendly designated birthing hospitals to 26% by 2020	
B) Reduce the disparity in breastfeeding initiation between non-Hispanic white women and non-Hispanic black women from an average of 12.1% to 11.9% by 2020	
Strategies	
A1) Support Michigan birthing hospitals' individual goals to continue movement along the Baby-Friendly pathway as identified through MIHEIP implementation A2) Continue and expand breastfeeding supportive practices by providing trainings and/or materials to 15 birthing hospitals A3) Encourage key partners to develop one specific strategy to support efforts to increase the number of Baby-Friendly hospitals	
B1) Increase training opportunities to improve the number, availability, and racial and cultural diversity of breastfeeding professionals B2) Facilitate collaborative community efforts in two communities to impact low breastfeeding initiation rates among women of color B3) Learn approaches to address disparities in breastfeeding rates by meeting annually with statewide groups that are explicit to supporting breastfeeding for non-white women	
ESMs	**Status**
ESM 4.1 - Percent of Baby-Friendly designated birthing hospitals in Michigan	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

State Action Plan Table (Michigan) - Perinatal/Infant Health - Entry 3	
Priority Need	
Foster safer homes, schools, and environments with a focus on prevention	
NPM	
NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding	
Objectives	
A) Increase percent of infants put to sleep on a separate approved sleep surface to 37.5% by 2020	
B) Increase percent of infants placed to sleep without soft objects or loose bedding to 57.1% by 2020	
C) Reduce the gap between non-Hispanic white women and non-Hispanic black women in following safe sleep guidelines by 2020	
Strategies	
A1, B1) Support safe sleep activities of local health departments and the Inter-Tribal Council of Michigan A2, B2) Support providers who educate families on safe sleep and facilitate new partnerships to make it possible for families to receive infant safe sleep education at all potential touchpoints A3, B3) Develop and disseminate safe sleep messages based in best practices and families' experiences A4, B4) Develop and disseminate tools for providers to have effective, non-judgmental, and culturally-sensitive conversations about safe sleep A5, B5) Support promotion of protective factors (i.e. smoking cessation, breastfeeding, immunizations)	
C1) Provide training and support to local health departments on health equity C2) Dedicate at least one infant safe sleep webinar annually to the topic of health equity C3) Send at least one message on the topic of health equity via the Infant Safe Sleep for Professionals list per quarter	
ESMs	**Status**
ESM 5.1 - Increase the number of Maternal Infant Health Program agencies that have staff trained to use the concepts of motivational interviewing with safe sleep	Active
ESM 5.2 - Increase the number of agencies that have implemented or revised/updated a safe sleep policy/protocol	Active
ESM 5.3 - Increase the number of hospitals that have implemented or revised/updated a safe sleep policy/protocol for the NICU	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

Child Health

State Action Plan Table (Michigan) - Child Health - Entry 1	
Priority Need	
Increase access to and utilization of evidence-based oral health practices and services	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
A) Increase the number of students who have received a preventive dental screening within a school-based dental sealant program	
Strategies	
A1) Utilize the SEAL! Michigan database to track the number of students annually receiving a preventive dental screening A2) Promote dental sealant programs through school health professionals A3) Prepare and analyze the SEAL! Michigan annual all grantee reports to monitor for annual growth of students receiving a preventive dental screening A4) Examine ongoing trends then identify geographic areas experiencing a high burden of disease and identify populations that will benefit from an increase in dental sealant placement in proportion to disease and population	
ESMs	**Status**
ESM 13.2.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

State Action Plan Table (Michigan) - Child Health - Entry 2

Priority Need

Foster safer homes, schools, and environments with a focus on prevention

Objectives

A) By 2020, increase by 20% from baseline the percent of Medicaid-enrolled children under age 6 with an elevated blood lead level (EBLL) from a capillary test who receive a venous lead confirmation test

B) By 2020, increase by 10% the percent of all children under age 6 with an elevated blood lead level (EBLL) from a capillary test who receive a venous lead confirmation test

Strategies

A1) Provide local health departments with data and lists of Medicaid-enrolled children who need venous testing A2) Flag, in the Michigan Care Improvement Registry (MCIR), the Medicaid-enrolled children that need venous lead testing

B1) Provide local health departments data to support targeted outreach to improve confirmatory testing B2) Provide Maternal and Child Health partners with educational materials about venous lead testing in various languages including Spanish, Arabic, and Bengali

State Action Plan Table (Michigan) - Child Health - Entry 3

Priority Need

Invest in prevention and early intervention strategies

Objectives

A) By 2020, increase the percentage of children 19-36 months of age who receive recommended vaccines to 75%

B) Enable local health departments to better track successes or shortfalls for their health jurisdiction

C) Implement the I Vaccinate Campaign

Strategies

A1) Use data in the Michigan Care Improvement Registry (MCIR) to identify all children 6-18 months of age who are overdue for a vaccine A2) Generate semi-annual letters to parents of children 6-18 months of age who are overdue for a vaccine

B1) Produce a quarterly report card for each county showing vaccination rates and rankings compared to other counties across the state B2) Produce quarterly reports showing vaccination levels of infants birth through 24 months showing vaccination drop off by series and vaccine B3) Produce county coverage levels by race for 19- to 36-month-old children and make the reports available to local health departments

C1) Secure funding for the implementation of the I Vaccinate campaign C2) Provide subject matter expertise to the website and messaging for social media and broadcasts

Adolescent Health

State Action Plan Table (Michigan) - Adolescent Health - Entry 1

Priority Need

Promote social and emotional well-being through the provision of behavioral health services

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

A) Increase the percent of adolescents, ages 12 through 17, enrolled in Medicaid, with a preventive medical visit in the past year

B) Of the health care providers who completed the Motivational Interviewing web course and the Motivational interviewing professional development training, 98% will report skills in effectively counseling youth on changing risky behaviors

C) Increase percentage of CAHC clients age 12+ with a positive depression screen who have documented follow-up

Strategies

A1) Develop a state plan to improve adolescent well-care, focusing on Medicaid-eligible youth A2) Convene a workgroup to promote comprehensive adolescent well-care A3) Expand strategies to incentivize well-child exams by working with health plans

B1) Increase the number of providers trained on culturally-competent adolescent-friendly care

C1) Establish Behavioral Health Quality Measures among Child & Adolescent Health Centers (CAHCs) C2) Implement CAHC CQI Initiative C3) Provide support to CAHC mental health providers to assure proper data collection and reporting for behavioral health quality measures, including appropriate follow-up, to clients with positive depression screens

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Michigan) - Adolescent Health - Entry 2

Priority Need

Invest in prevention and early intervention strategies

Objectives

A) By 2023, increase the percentage of adolescents who have completed the HPV series to 50%

B) Increase outreach to adolescent immunization providers with low immunization rates

Strategies

A1) Generate a letter using MCIR data to parents of adolescents who have initiated the HPV series but have not completed it A2) Partner with the MDHHS Cancer Program and the American Cancer Society to build a stakeholder group to promote HPV vaccination as cancer prevention A3) Partner with health systems in Michigan to develop strategies to increase HPV immunization rates for their members

B1) Using MCIR data, generate a list of adolescent providers and their MCIR completion rates B2) Prioritize provider outreach to larger practices with the lowest immunization rates B3) Offer quality improvement visits to provide a comprehensive assessment of immunization rates and recommendations for practice improvements B4) Generate HPV Report Cards for Federally Qualified Health Centers

Children with Special Health Care Needs

State Action Plan Table (Michigan) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Increase family and provider support and education for Children with Special Health Care Needs	
NPM	
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	
Objectives	
A) By 2020, increase the number of youth who have a plan of care that includes transition planning beginning at age 14 by 4.1%	
B) By 2020, increase the number youth and families by 10% that are aware and understand the transition to adulthood process	
C) Increase provider awareness and understanding of the transition to adulthood process by 25% through the establishment and offering of a free online Medical Transition course	
Strategies	
A1) Identify areas of improvement related to transition planning in MHPs A2) Provide continued support and technical assistance to local health departments (LHDs) related to transition A3) Continue the partnership with MSU Institute for health policy and the Michigan Association of Local Public Health to determine the best ways to engage LHDs to integrate care planning using CareConnect 360	
B1) Implement the marketing plan for the Adolescent Training Online Course B2) Establish adolescent transition as one of the quality improvement initiative options for MDHHS funded CAHC programs B3) Continue to partner with LHDs and other partners to offer education and training to improve knowledge of and resources for health care transition	
C1) Develop and implement online transition modules that offer free CEUs for physicians, nurses and social workers C2) Continue to support the CYE grant partners to improve transition for children and youth with epilepsy in rural communities	
ESMs	**Status**
ESM 12.1 - Percent of CSHCS clients age 18 to 21 years in selected diagnosis groups that have transferred care from a pediatric to an adult provider	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

State Action Plan Table (Michigan) - Children with Special Health Care Needs - Entry 2

Priority Need

Reduce barriers, improve access, and increase the availability of health services for all populations

Objectives

A) By 2020, reduce barriers to medical care and treatment by minimizing financial barriers from the increased medical services associated with the child's special need, as measured by a 5% increase in the Insurance Premium Payment Benefit Assistance

B) By 2020, improve access to medical care and treatment by improving the systems of care for CSHCN clients, as measured by the CMDS patient satisfaction survey

C) By 2020, increase the availability of health services, particularly in underserved regions, through the utilization of telemedicine and community-based services

Strategies

A1) Continue enrolling children with special needs into the medical care and treatment benefit, which provides payment for medical care and treatment related to the child's qualifying condition A2) Review the Insurance Premium Payment Assistance study's findings and implement a workplan to integrate at least two of the suggested improvements identified by the study into the program A3) Partner with the University of Michigan Partners for Children Program to support the ongoing development of a Michigan Palliative Care model A4) Implement a new database system to record donations to the Children's Special Needs Fund of CSHCS

B1) Continue to implement the CMDS site visit schedule, visiting approximately 1/4 of the CMDS clinics B2) Launch a website with resources for CMDS clinics and the pediatric intensive feeding program services B3) Explore and identify challenges in accessing services by populations served by both Community Mental Health (CMH) and CSHCS systems

C1) Utilize insights developed by the telemedicine workgroup to study the feasibility and barriers associated with specialist use of telemedicine C2) Work to assist CMDS clinics in learning more about how to coordinate care across disciplines in order to improve communication and satisfaction C3) Continue to provide training opportunities for LHDs that focus on care coordination, case management and locally based services C4) Utilizing a health equity lens, assess the CSHCS population to identify health disparities and address social determinants of health